

907 KAR 1:055  
Incorporation By Reference

MAP 100501  
Prospective Payment System Rate Adjustment  
November 2001 Edition  
(clean copy)

MAP 100601  
Scope of Services Survey Baseline Documentation  
November 2001 Edition  
(clean copy)

**ADOPTED: October 16, 2002**

Cabinet for Health Services  
Department for Medicaid Services  
275 East Main Street  
Frankfort, Kentucky 40621

# Prospective Payment System Rate Adjustment (Change in Scope of Services)

MAP 100501  
11/01 Edition

Line #

Interim Rate for  
Change in Service

Final Rate for  
Change in Service

(Column 1)

(Column 2)

Medicaid

Medicaid

## Cost of Existing Services:

- 1 Current PPS Rate
- 2 Medicaid Visits for Existing Services (Avg# of Visits for Base Years)
- 3 Total Medicaid Cost of Existing Services

Line 1 times Line 2

## Change in Service : (based on projected financials from provider)

- 4 Total Direct Cost Associated with Change in Service
- 5 Administrative Cost Allocation (Avg % of Adm Cost for Base Years as % of direct cost)
- 6 Total Cost of Change in Service

Provider Projection

Admin Cost % times Line 4

Line 4 plus Line 5

- 7 Medicaid Visits for Change in Service
- 8 Total Visits for Change in Service

Provider Projection

Provider Projection

- 9 Medicaid Visits as % of Total Visits
- 10 Total Medicaid Cost of Change in Service

Line 7 divide by Line 8

Line 6 times Line 9

## New Rate Calculation:

- 1 Total Medicaid Cost of Existing Services
- 2 Total Medicaid Cost of Change in Service
- Total Medicaid Cost of Existing Services and Projected Medicaid Cost of Change in Service

Line 3

Line 10

Line 11 plus Line 12

## Volumes for Existing and Change in Services:

- 14 Medicaid Visits for Existing Services
- 15 Medicaid Visits for Change in Service
- 16 Medicaid Volumes for Existing and Change in Services

Line 2

Line 7

Line 14 plus Line 15

## of Changed PPS Rate:

- 17 Total Medicaid Cost of Existing Services and Projected Medicaid Cost of New Service
- 18 Medicaid Volumes for Existing and Change in Services
- 19 Medicaid Interim PPS Rates
- 20 Medicaid Final PPS Rates

Line 13

Line 16

Column 1- Line 17  
divided by Line 18

Column 2- Line 17  
divided by Line 18

## Medicaid Reimbursement Reconciliation:

- 21 Medicaid interim PPS Rate
- 22 Medicaid Final PPS Rate (Year 1)
- 23 Difference
- 24 Actual Medicaid Volumes (Year #1)
- 25 Balance Due Medicaid / (Provider)

Column 1- Line 13

Column 2- Line 20

Column 2- Line 21 less  
Line 22

Column 2- Line 16

Column 2-Line 23 times  
Line 24



**SCOPE OF SERVICES SURVEY  
BASELINE DOCUMENTATION**

**Facility :** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**License Number:** \_\_\_\_\_

**Name of Chief Executive:** \_\_\_\_\_

**Name of Person Completing Survey:** \_\_\_\_\_

**Date of Survey:** \_\_\_\_\_

Instructions

With the implementation of a Prospective Payment System for Primary Care Centers and Rural Health Clinics, Centers and Clinics will complete this form for each separately licensed Center or Clinic to document services in the base year. If an organization operates multiple licensed primary care centers or RHC's, a form will have to be completed for each facility. Thereafter, this form will be completed during the annual licensure survey.

Cover Information requested is self explanatory

Page 2-3 Instructions

Page 4, No. 1 Documents services by primary care medical specialty (Page 4, No. 1.a provides ample room to list other services) If for example, the Center has a Family Practitioner who provides prenatal, deliveries, pediatrics, mental health, family care and inpatient services, then all cells should be checked.

Page 4, No. 1.a Provides space for other scope of service categories the Facility provides.

Page 5, No. 2 Listing of health education and outreach services the Facility provides to Medicaid and other patients. Services of these types are required to have a Facility license. These services generally **do** not generate a billable encounter. Examples would include nursing education, diabetic counseling, prenatal education, screening at a housing project, school nurse programs, etc.

- Page 5, No 3. Requires documentation of the level of laboratory services provided. Refer to your **CLIA** certifications for the proper response.
- Page 5, No. 4 Document radiology services provided.
- Page 5, No. 5 Facility's supplemental services are listed. At least two of these services must be provided directly to obtain a primary care license. Other services, such as pharmacy and home health can be provided, but are generally not billed as a primary care service. Report only those services reimbursed under the Facility's PPS rate.
- Page 6, No. 6 List Extension (satellite) locations.
- Page 6, No. 7 Document holding beds.
- Page 7, No. 8 Other services not documented elsewhere in this survey, should be listed. Example: could include transportation services or other services included in the Facility's base PPS rate.
- Page 7, No. 9 - 11 Documents changes in scope and provides an affirmation and attestation of the validity of the information provided.
- Page 7 Signature and Date line for the Chief Executive of the Facility.

Specialty	Scope of Services Category							
	OB Prenatal	OB Deliveries	Peds	Family or General Medicine	Mental Health	Geriatrics	Inpatient	
Family Practice								
Internal Medicine								
Obstetrics								
GYN								
Peds								

**Ia. Checklist of Basic Medical and Diagnostic Treatment Services (Continued)**

Specialty	Scope of Services Category							

2. List health education and outreach services that do not generate a Medicaid billable encounter. (Such as diabetic counseling, smoking cessation, etc.)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Does the Facility provide Laboratory Services?

\_\_\_\_\_ Yes \_\_\_\_\_ NO (all **labs** are send outs)

If yes: What level of Laboratory Service does the Facility Provide? \_\_\_\_\_

4. Does the Facility provide X-Ray Services?

\_\_\_\_\_ Yes \_\_\_\_\_ NO

If yes: List various modalities provided, i.e.: routine diagnostics, mammography, ultrasound, etc.

_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Identify Supplemental Services provided by the Facility under its Primary Care License and reimbursed under the Facility's PPS rate.

Pharmacy	_____ YES	_____ NO
Dentistry	_____ YES	_____ NO
Optometry	_____ YES	_____ NO
Midwifery Services	_____ YES	_____ NO
Family Planning	_____ YES	_____ NO
Nutrition services provided By a qualified Dietitian or Nutritionist	_____ YES	_____ NO

Social Services Counseling  
Provided by a licensed  
Social Worker

\_\_\_\_\_YES

\_\_\_\_\_NO

Home Health  
(licensed agency)

\_\_\_\_\_YES

\_\_\_\_\_NO

6. Does the Facility have Extension Services (i.e. satellites) under its Primary Care License and included under the Facility's PPS rate?

\_\_\_\_\_Yes

\_\_\_\_\_No

If yes: List each Extension Service and their respective license numbers.

Extension Service Name

License # and/or Location

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7. Does the Facility currently operate holding beds as a service?

\_\_\_\_\_Yes

\_\_\_\_\_No

8. Are there other services currently provided which have not been reported in other sections of this document?

If yes: please list.

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9. Does this report reflect any changes in scope of services?

[ ] Yes - Increase in services

[ ] Yes - Decrease in services

[ ] No Change



10. If a decrease in scope of services has occurred, does it affect encounter cost?

☐ Yes - Estimated increased

☐ Yes - Estimated decreased

☐ No Change in rate cost

11. Is a rate change being requested based on the increase in scope of service?

☐ Yes

☐ No

I attest and affirm that to the best of my knowledge all information is correct.

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Facility's Chief Executive

Date